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In The

Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC., and
GREATER NEWPORT PHYSICIANS, INC.,

Petitioners,

v.

BARBARA MCCALL,
Individually and as Trustee, etc.,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of California

RESPONDENT'S BRIEF IN OPPOSITION

RUSSELL S. BALISOK
STEVEN C. WILHEIM
HOUCK & BALISOK
P.O. Drawer 8170
Universal City, CA 91618
(818) 506-7890

CAROL S. JIMENEZ*
LAW OFFICE OF
CAROL S. JIMENEZ
5182 Katella Avenue
Suite 106
Los Alamitos, CA 90720
(562) 430-0239

Counsel for Respondent

Counsel of Record

August 30, 2001

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether state law claims against a Medicare-subsidized HMO, which is required under the Medicare Act (42 U.S.C. § 1395mm(b)) to operate under state law, that are outside the scope of the Medicare administrative process fall within Medicare's exclusive administrative review provisions.

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RESPONDENT'S BRIEF IN OPPOSITION

Respondent Barbara McCall respectfully requests that this Court deny the petition for writ of certiorari. The petition seeks review of the opinion of the California Supreme Court affirming reversal of the trial court's order, which sustained Petitioners' demurrers to the complaint without leave to amend.

OPINIONS BELOW

The opinion of the Supreme Court of California is published at 25 Cal.4th 425 (2001) and the opinion of the Court of Appeal of the State of California, Fourth Appellate District, is published at 74 Cal.App.4th 257 (1999).

STATUTORY PROVISIONS INVOLVED

Petitioners set forth two of the statutory provisions, 42 U.S.C. §§ 405(g) and 405(h), relevant to the opinion below. In addition, the following statutory provision is critical to the analysis of the issues underlying the Petition.

42 U.S.C. § 1395mm(b)[1] sets forth the requirements that HMOs must meet in order to provide care to Medicare beneficiaries, providing in pertinent part that:

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[1] As noted by the California Supreme Court, subsequent to the events in this case, Congress enacted a new part of Medicare called "Medicare + Choice" (Pub.L. No. 105-33 (Aug. 5, 1997) 111 Stat. 328, codified at 42 U.S.C. §§ 1395w-21 *et seq.*). Effective January 1, 1999, this new law applies to HMOs such as PacifiCare, instead of the law at issue in this case. App. 14a.

> For purposes of this section, the term 'eligible organization' means a public or private entity (which may be a health maintenance organization or a competitive medical plan) *organized under the laws of any State* . . .

(Emphasis supplied.)

STATEMENT OF THE CASE

George McCall, the now deceased husband of respondent Barbara McCall, enrolled in the HMO operated by petitioners PacifiCare of California, Inc. and PacifiCare Health Systems, Inc. (jointly "PacifiCare"), which was paid a flat monthly fee by Medicare to care for George no matter how much care he needed. As required by Medicare law and by state law, PacifiCare was licensed by the State of California and was required to operate under the provisions of California law. Petitioner Greater Newport Physicians, Inc. ("GNP") was the medical group that PacifiCare arranged to help it provide medical care to George.

In 1997, George became extremely ill due to progressive lung disease. Neither PacifiCare nor GNP denied George coverage of a particular service. Rather, PacifiCare and GNP refused to care for George altogether and intentionally withheld information from George about available treatment options, knowing that their actions would cause George's health to continue to deteriorate, would cause George to continue to suffer the debilitating and life-threatening effects of his progressive lung disease, and would likely cause George's untimely death.

When McCall learned about available treatment options from another source and asked PacfiCare and GNP about them, PacifiCare and GNP forced George to disenroll from PacifiCare in order to obtain them. Petitioners forced George to disenroll from PacifiCare for no reason other than to save themselves money, as once George was disenrolled from PacifiCare, the Medicare program and not Petitioners would pay the cost of George's care.

McCall brought this action in state court in 1997. McCall alleges eight causes of action for tort damages based on claims of negligence, wilful misconduct, four counts of fraud including fraudulent misrepresentation and constructive fraud, and intentional and negligent infliction of emotional distress, as well as a ninth cause of action for injunctive relief from unfair business practices, all under state law. As part of the state law causes of action, McCall alleges violation of a wide range of state law requirements and also alleges violation of selected provisions of Medicare law that are unrelated to benefits determinations, such as the duty not to encourage George to disenroll from PacifiCare. McCall does not seek any Medicare covered benefit, either directly or indirectly.

Petitioners' description of the allegations in this case is simply wrong. For example, Petitioners' "critical point" (at p. 5) that "Each count [of Respondent's complaint] was based on alleged violations of duties under the Medicare Act, most notably the duty to provide coverage for a lung transplant at UCSD" embellishes the complaint and the opinion below with allegations and statements that

are nowhere to be found.[2] McCall's claims do not rest on petitioners' alleged violations of duties under the Medicare Act. *See, e.g.*, App. 76a, 79a, 82a, 88a-89a.

PacifiCare and GNP demurred to the First Amended Complaint on the ground that all of McCall's claims are preempted by federal Medicare law. The trial court sustained PacifiCare's and GNP's demurrers without leave to amend, and entered judgment in their favor. The appellate court reversed the trial court's judgment.

The California Supreme Court granted review on the sole question of whether state law claims against a Medicare-subsidized HMO fall within Medicare's exclusive review provisions. The California Supreme Court concluded that none of the claims presented by McCall fall within Medicare's exclusive review provisions, stating that "[a] Medicare provider may violate state common law or statutory duties owing to beneficiaries, unrelated to its Medicare coverage determinations." App. 16a. In reaching this conclusion, the court carefully reviewed the allegations and elements of each cause of action in the complaint (App. 2a-3a,16a-18a), the language and legislative history of the Medicare Act (App. 12a-13a), the case

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[2] Petitioners' footnotes also misstate this case. For example, the allegations they offer in footnote 3 (at p. 3) are nowhere to be found in the complaint. The unsigned, uncertified excerpt from Volume 3 of the Deposition of George McCall is not part of the record, was not considered by any of the courts below, and may not be considered on demurrer, the motion at issue in the court below. See *Alcorn v. Anbro Engineering, Inc.*, 2 Cal.3d 493, 496 (1970). Similarly, footnote 4 (at p. 4) contains "facts" that are not part of the record, not found in App. 2a, footnote 1, which it cites as support, and are in fact incorrect.

law interpreting the Medicare Act including the cases relied on by Petitioners (App. 5a-10a, 19a), and HCFA's[3] explicit analysis and interpretation of the Medicare Act as it relates to the question presented (App. 14a-15a).

Petitioners wrongly identify (at p. 7) as the California Supreme Court's holding in the *McCall* case, the court's discussion of the holding and rationale in a California Court of Appeal case, *Redmond v. Secure Horizons, Pacificare, Inc.*, 60 Cal.App.4th 96 (1997). App. 12a. The California Supreme Court did *not* hold, as Petitioners assert, that "the McCalls' claims did not arise under the Medicare Act, even though they were premised on the alleged violations of duties under that Act. . . . " To the contrary, the court found that the claims presented by McCall were *not based* on the HMO's alleged failure to provide Medicare covered benefits. App. 16a-18a. Petitioners also erroneously imply (at p. 2) that allegations that are unrelated to benefits determinations should nevertheless proceed through the Medicare administrative appeals process, even though such allegations are clearly outside its scope. See App. 15a; 42 C.F.R. §§ 417.600, 417.604, 417.606. The California Supreme Court found that none of McCall's claims requires a Medicare coverage determination, none seeks at bottom payment or reimbursement of a Medicare claim, none falls within the Medicare administrative

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[3] HCFA stands for the Health Care Financing Administration, which until recently was the name of the federal agency charged with administering the Medicare program. Since Petitioners refer to the federal agency as HCFA rather than by its current name, Center for Medicare and Medicaid Services, Respondent will do the same.

review process, and none is remediable through the Medicare administrative review process. App. 18a-19a.

By the opinion below, the Supreme Court of California has ordered that the judgment against McCall be reversed and that Petitioners' demurrers be overruled. This case may now proceed to trial and there is no way to predict whether McCall will prevail on any of the claims against PacifiCare and GNP.

REASONS FOR DENYING THE PETITION

Review is unwarranted for three reasons. First, a proper jurisdictional basis is lacking because the state court decision below is not a "final judgment" within the meaning of 28 U.S.C. § 1257. *Jefferson v. City of Tarrant*, 522 U.S. 75 (1997); *Flynt v. Ohio*, 451 U.S. 619, 622 (1981). Second, there is no conflict among the federal circuit courts or state high courts of last resort regarding the question presented here. Third, the decision below is correct.

I. THIS COURT LACKS JURISDICTION TO REVIEW THE NON-FINAL DECISION BELOW.

"This case, still *sub judice* in [California], was brought to this Court too soon." *Jefferson v. City of Tarrant*, 522 U.S. at 77. This Court's review of state-court decisions is limited to "[f]inal judgments or decrees rendered by the highest court of a State in which a decision could be had." 28 U.S.C. § 1257(a). Here, the ruling of the California Supreme Court affirms the appellate court's ruling

reversing the trial court's judgment against McCall. The case has now been remanded for further proceedings and may now proceed to trial. App. 1-5. Thus, the decision below does not qualify as a "final judgment" within the meaning of Section 1257.

This Court has identified four categories of cases that constitute exceptions to the finality requirement of Section 1257. *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 477-87 (1975). As to the first three, this Court recognizes exceptions where (1) "the federal issue is conclusive or the outcome of further proceedings preordained," (2) the federal issue "will survive and require decision regardless of the outcome of further state court proceedings," and (3) "later review of the federal issue cannot be had, whatever the ultimate outcome of the case." *Id.* at 479-81; *see also Jefferson v. City of Tarrant*, 522 U.S. at 82. As to these three categories, the judgment involved here does not even arguably apply. If Petitioners prevail on remand, the question presented will no longer require decision. Thus, as in *Jefferson v. City of Tarrant*, "[t]he outcome of those further proceedings could moot the federal question" presented here. 522 U.S. at 77. On the other hand, if Petitioners do not prevail on remand, they "will be free to seek [Supreme Court] review when the state-court proceedings reach an end." *Id.*

The fourth exception has two requirements. First, the state court judgment must represent the final word within the state court system on a federal issue, "with further proceedings pending in which the party seeking review here might prevail on the merits on nonfederal grounds, thus rendering unnecessary review of the federal issue by this Court, and where reversal of the state

court on the federal issue would be preclusive of any further litigation on the relevant cause of action." In addition, "a refusal immediately to review the state-court decision" must present a risk of "seriously erod[ing] federal policy." *Cox Broadcasting*, 420 U.S. at 482-83.

This category is also inapplicable here. Allowing this case to proceed to final judgment, rather than immediately reviewing the decision below, does not risk "seriously erod[ing]" any federal policy. Petitioners are required by Medicare law to operate under the laws of the State of California and, as discussed *infra*, the opinion below has no impact on the Medicare program. *Cf. Southland Corp. v. Keating*, 465 U.S. 1, 6-8 (1984) (allowing adjudication of dispute where parties had contracted for arbitration might erode federal policy embodied in Federal Arbitration Act); *Belknap v. Hale*, 463 U.S. 491, 497 n.5 (1983) (allowing case to go forward would risk eroding federal policy requiring matter at issue to be decided by NLRB, not by state courts); *Cox Broadcasting*, 420 U.S. at 485-87 (delaying review would leave important question regarding freedom of press in "uneasy and unsettled constitutional posture [that] could only further harm the operation of a free press"). Therefore, this case does not satisfy the requirements of the fourth exception.

Since this case may now proceed to trial, there has been no "final judgment" within the meaning of Section 1257. Thus, Supreme Court jurisdiction is lacking.

II. NO CONFLICT EXISTS AMONG ANY FEDERAL CIRCUIT COURTS OR STATE HIGH COURTS ON THE QUESTION PRESENTED.

Six different federal courts have published opinions directly on point with the issue raised by Petitioners. Without exception, each of these courts has found that state law claims, including those seeking tort remedies based upon failure to provide Medicare covered services, may be asserted against an HMO or other health care provider as they do not arise under the Medicare Act. *Ardary, et al. v. Aetna Health Plans of California, Inc., et al.*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251 (1997); *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997); *Plocica v. Nylcare of Texas, Inc.*, 43 F.Supp.2d 658 (N.D. Tex. 1999); *Winkler v. Interim Services, Inc.*, 36 F.Supp.2d 658 (M.D. Tenn. 1999); *Zamora-Quezada, et al. v. HealthTexas, et al.*, 34 F.Supp.2d 433 (W.D. Tex. 1998); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998).

Whether state law claims must go through the Medicare administrative review process was addressed in *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251 (1997). In *Ardary*, Justice O'Scannlain explained that the Ninth Circuit could find nothing in either the language or the legislative history of the Medicare Act that suggested Congressional intent to abolish all state remedies for torts committed by a Medicare provider. Although the complaint in *Ardary* did not seek recovery of Medicare benefits, it was undisputed that all of the claims were predicated on the allegation that a Medicare covered benefit had been wrongfully denied. (*Ardary v. Aetna*, 98

F.3d at 498.) Applying *Heckler v. Ringer*, 466 U.S. 602 (1984), and *Weinberger v. Salfi*, 422 U.S. 749 (1975), the Ninth Circuit found that the standing for the six tort claims was state common law theories and not the Medicare Act.

In *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997), a Medicare beneficiary challenging discharge from a nursing home alleged violations of Medicare law regarding residents' rights including laws governing discharge and quality of care. The Fourth Circuit found that the Medicare administrative review process did not encompass all of plaintiff's claims and did not afford the relief sought by plaintiff. Since plaintiff's claims were not for benefits under the Medicare Act, but rather for damages resulting from violation of certain of its provisions, Medicare's exhaustion of administrative remedies requirement did not apply. *See also Alacare, Inc.-North v. Baggiano*, 785 F.2d 963 (4th Cir. 1997) (The Eleventh Circuit reached a similar conclusion with respect to claims by a Medicaid patient); *Plocica v. Nylcare of Texas, Inc., et al.*, 43 F.Supp.2d 658 (N.D. Tex. 1999) (The Medicare Act does not preempt common law claims against a Medicare HMO for alleged inadequate quality of care and treatment); *Winkler v. Interim Services, Inc.*, 36 F.Supp.2d 1026 (M.D. Tenn. 1999) (Tort and other claims by Medicare beneficiaries against a Medicare provider for failure to provide medically necessary care because of cost considerations are not preempted by 42 U.S.C. §§ 405(g) and (h) because they do not seek anything of the Secretary or the U.S. government); *Zamora-Quezada, et al. v. HealthTexas, et al.*, 34 F.Supp.2d 433 (W.D. Tex. 1998) (Medicare's exhaustion of administrative remedies requirement does not

apply to claims by beneficiaries against their HMOs alleging state law causes of action as well as violations of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998) (state law tort claims against a Medicare HMO that are related to services under Medicare but do not seek to recover Medicare benefits are wholly collateral to a claim for benefits and thus are not preempted by Medicare).

Petitioners fail to apprise (at pp. 11, 18-19) this Court of the numerous federal cases directly on point with the present case (and cited by both the California Supreme Court and the Court of Appeal in their decisions (App. 8a-9a, 45a-47a)) and that the opinion below is in conformity with every published federal court opinion regarding the question presented here.

Instead of discussing the case law directly on point, Petitioners focus on federal court cases that have been brought by medical providers against the Secretary of DHHS (or her fiscal intermediaries, whose sole role is to process claims for payment by the Secretary) and have involved an issue of claims processing or termination of their own contract with the Secretary. See Petition at pp. 11, 14, 16-18, citing *Bodimetric Health Services, Inc. v. Aetna Life and Casualty*, 903 F.2d 480 (7th Cir. 1990), *Midland Psychiatric Associates, Inc. v. United States*, 145 F.3d 1000 (8th Cir. 1998), and *Affiliated Professional Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999). The present case is not brought by a provider against the government, but rather is brought by a patient against those making treatment decisions, and the present case does not involve claims processing or federal funds. By focusing

on inapposite cases, Petitioners claim a conflict between the decision of the California Supreme Court and the federal courts that simply does not exist.

III. THE DECISION BELOW IS CORRECT.

An examination of the Medicare Act itself, its legislative history and HCFA's interpretation of it underscores the correctness of the opinion below. As the court below noted, *the Medicare Act explicitly requires HMOs to operate under state law* (42 U.S.C. § 1395mm(b))[4] and prohibits any federal officer or employee from exercising any supervision or control over the manner in which medical services are provided or over any institution providing health services (42 U.S.C. § 1395). App. 13a-14a. Nothing in the legislative history of the Medicare Act indicates that Congress intended to obliterate state laws governing Medicare-subsidized HMOs including state tort remedies. See *Ardary v. Aetna*, 98 F.3d at 501-502; App. 12a-14a. The court below also reviewed HCFA's interpretation of the law, which plainly states that tort and other state law claims against an HMO are not preempted, even if such claims also involve Medicare coverage determinations. App. 14a-15a, citing 63 Fed. Reg. 34967, 35012, 35013

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[4] In contrast to the Medicare Act which is at issue here, the express language of a different federal statutory scheme, the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, governing employee benefit plans including health insurance, does preempt state tort law. ERISA specifically provides that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a); App. 13a.

(June 26, 1998). *See also U.S. v. Mead Corp.*, ___ U.S. ___, 121 S.Ct. 2164 (2001) (In a program for which Congress has delegated rule making authority, courts should accord great deference to interpretations promulgated pursuant to the Administrative Procedure Act by the implementing administrative agency); *Chevron USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). HCFA's view makes sense in light of the fact that Medicare beneficiaries who receive medical care in the fee-for-service system can bring state tort claims against medical providers for bad care and treatment decisions. There is nothing legally or logically different about Medicare beneficiaries who receive medical care from HMOs bringing state tort claims against their HMOs and other medical providers for bad care and treatment decisions.

The correctness of the decision below is also highlighted by the disparity between how the Medicare Act treats fiscal intermediaries and carriers (jointly referred to herein as "intermediaries"), on the one hand, and HMOs, on the other hand. Intermediaries are insurance companies with which Medicare contracts to process fee-for-service claims on behalf of the Secretary. 42 U.S.C. § 1395h(i). The Secretary and intermediaries neither provide nor arrange for medical care; they simply make after the fact determinations as to payment. Intermediaries determine claims for payment and then pay allowed claims using federal funds, not their own funds. 42 U.S.C. §§ 1395h (Part A claims) and 1395u (Part B claims). The Secretary provides the intermediaries the funds to pay claims and simply pays the intermediaries an administrative fee for performing this function. *Id.* The Secretary,

and not intermediaries, is liable for any payments certified by intermediaries for payment. 42 U.S.C. §§ 1395h(i) (fiscal intermediaries) and 1395u(e) (carriers).

In contrast, HMOs that serve Medicare beneficiaries do not simply pay claims for services already rendered; they actually provide or arrange for care. 42 U.S.C. § 1395mm(c)(4); 42 C.F.R. §§ 417.401, 417.414, 417.416. The Medicare program pays such HMOs a flat amount per month per enrollee, regardless of the frequency, extent or kind of health services actually provided to, paid for, or needed by a member. 42 U.S.C. §§ 1395mm(a)(1), (a)(4), (b)(1). The HMO, and not the Medicare program, is liable for any care needed by a member and for any payments to be made for a member's care (42 U.S.C. §§ 1395mm(b), (g)(6)), and the HMO profits from any remaining balance. The monthly amount the Medicare program pays an HMO is completely unaffected by any HMO administrative costs or by the HMO's liability for claims or tort damages. *Id.*

In addition, only limited types of claims, called "organization determinations," may be funneled through the administrative review process. All other types of claims are considered to be "grievances" and are specifically excluded from administrative review. 42 U.S.C. § 1395mm(c)(5); 42 C.F.R. §§ 417.600, 417.604(a), 417.606. Included in the broad category of grievances are issues regarding marketing problems, quality of care and involuntary disenrollment. *Id.; see also* 42 C.F.R. §§ 417.428(b)(2), 417.460(a). Thus, by definition, as noted by the court below (App. 15a-18a), McCall's claims are outside the scope of Medicare's administrative review.

The decision of the court below is based on the language of the Medicare Act, its legislative history, the uniformly consistent case law regarding the issue presented here, and the distinguishable case law involving claims against intermediaries and carriers which has been offered by Petitioners. The opinion of the court below is correct.

IV. THE IMPACT OF THE DECISION BELOW IS LIMITED.

A. The Decision Below Is Limited in Scope.

Petitioners argue (at p. 25) that this case opens the door for Medicare beneficiaries, and even Social Security recipients, nationwide to sue Medicare carriers and intermediaries when their benefit claims are denied. As discussed above, this case brings California into conformity with the federal courts. The impact of this case is limited to California Medicare beneficiaries who have claims against their HMOs that do not fall within the scope of the Medicare administrative review process. App. 1a. Moreover, as noted by the California Supreme Court, its decision is based upon the law prior to the Balanced Budget Act of 1997 (Pub.L. No. 105-33 (Aug. 5, 1997) 111 Stat. 328, codified at 42 U.S.C. §§ 1395w-21 *et seq.*), which governs Medicare HMOs including PacifiCare effective January 1, 1999. App. 14a-15a. Thus, the impact of this case may be limited in time as well.

B. The Decision Below Does Not Impact the Operation or Finances of the Medicare Program or Federal Treasury.

Petitioners also suggest (at pp. 26-28) that the decision below will increase the costs of administering the Medicare program, will divert scarce federal resources to state court litigation, and will have a dramatic impact on federal funding of Medicare. Petitioners cite no authority for such propositions because none exists. Petitioners erroneously portray the way the Medicare program operates and the way the Medicare program pays HMOs.

As stated above, the Secretary pays HMOs a predetermined flat amount per month per enrollee, regardless of the frequency, extent or kind of health services actually provided to or paid for a member's care. 42 U.S.C. §§ 1395mm(a)(1), (b)(1). HMOs actually provide or arrange for care, and the Medicare program's cost or liabilities are not affected by the amount of care needed by the HMO's Medicare members or by the amount of claims against the HMO. 42 U.S.C. § 1395mm(c)(4). The Medicare program has no liability for the HMO's obligations. 42 U.S.C. §§ 1395mm(a)(1), (b)(1), (c)(4). In fact, if the Medicare program pays any amount that should have been paid by the HMO, the Medicare program may recoup such amounts from the HMO. 42 U.S.C. § 1395mm(g)(6). The funds for enrollees' medical care and for paying enrollees' claims come directly out of Petitioners' proverbial pocket and Petitioners profit by any monies not spent on enrollees' care. The particular type of care or claim that might be at issue has no impact on federal funds.

CONCLUSION

Petitioners' petition for a writ of certiorari should be denied.

Respectfully submitted,

RUSSELL S. BALISOK
STEVEN C. WILHEIM
HOUCK & BALISOK
P. O. Drawer 8170
Universal City, CA 91618
(818) 506-7890

CAROL S. JIMENEZ*
LAW OFFICE OF CAROL S. JIMENEZ
5182 Katella Avenue, Suite 106
Los Alamitos, CA 90720
(562) 430-0239

Counsel for Respondent

**Counsel of Record*

No. S082236

IN THE SUPREME COURT OF CALIFORNIA

REMITTITUR

TO THE Court of Appeal,
Fourth Appellate District, Division Three

BARBARA McCALL, Individually and as Trustee, etc.,	S082236 Ct. App. #G024030 Orange County Superior Court – Main Super. Ct. No. 788545
Plaintiff and Appellants,	
v.	
PACIFICARE, et al.,	
Respondents.	

I, FREDERICK K. OHLRICH, Clerk of the Supreme Court of the State of California, do hereby certify that the attached are copies of the original judgment now final entered in the above-entitled cause on May 3, 2001.

Costs, if any, shall be awarded by the Court of Appeal.

WITNESS MY HAND AND
OFFICIAL SEAL OF THE COURT,
06/06/2001

FREDERICK K. OHLRICH, Clerk

[SEAL]

By /s/ Deborah Benko
DEPUTY

[Attached Opinion Of The Supreme Court Of California Omitted In Printing.]

COURT OF APPEAL – STATE OF CALIFORNIA
FOURTH APPELLATE DISTRICT
DIVISION THREE

Carol S. Jimenez
5182 Katella Avenue
Suite 106
Los Alamitos, CA 90720

GEORGE McCALL et al.,
Plaintiffs and Appellants,

v.

PACIFICARE OF CALIFORNIA, INC.,
Defendant and Respondent.

G024030
788545

REMITTITUR

I, Stephen M. Kelly, Clerk/Administrator of the Court of Appeal of the State of California, for the Fourth Appellate District, Division III, do hereby certify that the decision entered in the above-entitled cause on December 6, 1999 has now become final.

[X] Appellant [ ] Respondent to recover costs
[ ] Each party to bear own costs
[ ] Costs are not awarded in this proceeding
[ ] See decision for costs determination

Witness my hand and the Seal of the Court affixed at my office this June 14, 2001.

Stephen M. Kelly
Clerk/Administrator

By: /s/ Diane R. Hernandez
Deputy Clerk

cc: All Counsel (copy of remittitur only, California Rules of court, Rule 25(e)).

SUPERIOR COURT OF CALIFORNIA
COUNTY OF ORANGE,
CENTRAL JUSTICE CENTER
MINUTE ORDER

Department: C24

COURT CONVENED AT: **ON:** 7-12-2001

JUDGE/COMM:
THIERRY P. COLAW

CLERK: C. FALKENBERG

REPORTER:

BAILIFF:
M. AGUILAR

AND THE FOLLOWING PROCEEDINGS WERE HAD:

788545 MCCALL VS PACIFICARE

NO APPEARANCES.

IN ACCORDANCE WITH SUPREME COURT RULING DIRECTING THE TRIAL COURT TO REVERSE THE RULING OF 7-17-2001 [SIC], THE COURT HEREBY RULES AS FOLLOWS: THE ORDER DISMISSING THE ACTION AND SUSTAINING THE DEMURRER OF PACIFIC CARE AND GREATER NEWPORT PHYSICIANS WITHOUT PREJUDICE IS VACATED. COURT RULES THAT THE DEMURRER IS OVERRULED WITH 30 DAYS LEAVE TO ANSWER. PLAINTIFF TO GIVE NOTICE. ENTERED 7-12-2001

HOUCK & BALISOK, RUSSELL BALISOK, 535 NORTH BRAND BLVD., STE 501, GLENDALE, CA 91203

CERTIFICATE OF SERVICE BY MAIL

I, ALAN SLATER, Executive Officer/Clerk of the Superior Court, in and for the County of Orange, State of California, hereby certify that I am not a party to the within action or proceeding and that on July 12, 2001, I served a copy of this document on the parties named herein by depositing true copies, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail box at Santa Ana, California addressed as indicated above.

Dated: July 12, 2001 by CHRISTINE FALKENBERG,
Deputy Clerk
Chris Falkenberg